Inquiry into Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians: submission by AFMW 30/09/2021

Thank you for granting the Australian Federation of Medical Women (AFMW) the opportunity to contribute to the Inquiry into Provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians. We represent the collective voice of medical women in Australia and address health equity issues through the gender lens, which includes issues of age, marginalisation and intersectionality also. There are around 40,000 general practitioners in Australia, of whom nearly 50% are women. Some refer to this as a 'feminisation' of the specialty however, it is a 'normalisation' of the profession and with this change over time, the needs of doctors who serve the communities have also changed, so the gendered lens needs to be considered and is embedded in our recommendations below. The ultimate purpose of such an inquiry is to improve health outcomes for people living in rural and remote Australia, yet to achieve this, we need to enhance the conditions and opportunities for doctors who build their life around supporting these communities.

a) The current state of outer metropolitan, rural, and regional GPs and related services;

All Australians have the right to continuity of care from a trusted primary care physician, yet the percentage of graduates choosing General Practice plummets every year. This is at a time when we need Government to be increasing this specialty workforce. There are several reasons for this continued decline:

Income during GP training is lower compared to hospital-based doctors in training:
General Practice is not an attractive choice for the new graduate. There is a disincentive to train as a GP due to an immediate reduction of income of around 30% when leaving the hospital setting to enter the GP training programme. This is compounded by the fact GP trainees early in their training a required to have longer appointments, and therefore fewer appointments each day, and their daily billing is less. When compared to their hospital counterparts in other specialty training programmes, this denotes a lower perceived value of the specialty training programme, as compared to other specialty training programmes. As an example, the commonly used term, 'just a GP' is often coined by members of the community and by other specialist colleagues, and implies that GP work is simple and undervalued.

The potential for income earned varies according to whether or not the practice is a bulk-billing only centre or a fee paying practice. The bulk billing practices tend to pay their trainees less or the capacity to earn is reduced due to the nature of the income break down being based on percentage of amount generated by the GP trainee. This reduced income disincentive, particularly in recruiting and retaining staff at bulk-billing practices, further exacerbates the socioeconomic divide in providing accessible and affordable of health care at a population level, often for those with particularly complex healthcare needs and those who are most vulnerable.

Salary packaging is readily available for hospital-based doctors, but less so for GPs, thereby restricting their access to the benefits in reducing the amount of tax they need to pay for their given income compared with their hospital-based colleagues.

Entitlements:
GP trainees cannot carry their holiday leave entitlements from one general practice training centre to another. Unlike hospital-based trainees where their entitlements can be transferred.

Part-time training arrangements and subsidised childcare services particularly for rural trainees:
Doctors in training are older, meaning they might already have families. This is due to the undergraduate training programmes requiring a basic 3 years in most universities, followed by a course in medicine. By the time they graduate from medicine, many have already started families which means parental leave, childcare support, flexible work and training schedules (for example part-time work) are especially important. Maternity leave offered to GP trainees is significantly less than for hospital-based registrars, and parental leave, even more-so. Childcare facilities in rural training regions are unavailable or inaccessible for many. Additionally, the requirement to change clinics each training semester, in order to enrich a trainee's experience, can also create family upheaval if required to relocate or work further afield, especially if on-call. In short, the current programme disadvantages GPs with young families significantly. Job share has been discussed at many levels and yet is not properly supported by a profession and health care system that openly talks about the importance of work/ life balance. More flexibility and support in work and training requirements, regardless of whether one has family commitments, is important for reducing burnout, a safe workplace, patient safety, and providing overall flex and sustainability in all areas of health care.

It is evident that the problem then is not rural, but a general GP workforce crisis, both urban and rural. However, what is a problem in the cities is compounded by the tyranny of distance in regional and remote Australia. This unattractiveness of general practice should not have to be worse the more distant the GP is from services and urban benefits.

Some recommended solutions

1. **Federally subsidise salaries for GPs in training is required.**
   a) Single employer model of remuneration for general practice training can disadvantage the GP practice that undertakes the training of GP trainees as COVID -19 has clearly demonstrated.

   b) Private practices that charge a co-payment were forced to bulk bill all telehealth services and the ability for trainee GPs to earn and work was impacted. Some have had to 'join job-keeper' support and seek other forms of employment; this was worse in the metropolitan sectors.

      i. General practice was the only medical profession that was mandated to bulk bill all services provided by telehealth, thereby slicing the income of some practices beyond survival thresh hold. The flow on from this, is the perception that general practice is undervalued by the Government

2. **Maintain and support Telehealth**

   a) Telehealth MBS items are a good example of what has been immensely successful in urban regions post COVID due to the ability for GPs to reach their patients during lockdowns. The uptake of Telehealth also reflects the need for flexibility in the technological means doctors and patients communicate with each other. Some

patients engage more readily with care services where otherwise they may not have – given the time, time out of paid and unpaid work, transport, and other barriers to care if face-face. The ability for doctors to bill (albeit bulk-billed only) for these appointments also reflects much work done previously over the phone that doctors were not paid for.

b) Telehealth needs to be escalated for rural regions. All GP discussions need to be "rural proofed".

3. Incentivisation and tax breaks for GPs working in the rural sectors also need to occur

Further, rural-only incentives would "differentiate to equalise". This should give workforce, including new graduates, certain benefits if they *settle* in the MMM3-7 region, not just work there for a brief period. Some potential examples of rural-only incentives are:

- rural differential MBS Billings
- increased rural incentive payments
- tax-free upgraded infrastructure grants.
- The current infrastructure grant system is discouragingly restrictive. It would be fairer for grants to recognise deeper rurality.
- equipment subsidies;
- paid holiday time off, a rural perk.
    - NB: The self-employed GPs do not get holidays unless the work is covered by colleagues. There are ongoing expenses. The rural doctor needs special consideration in the form of
- locum and overhead payment subsidies
- a rural retirement savings (superannuation) contributions. In other words a government medical workforce pension plan, the higher the MMM (above 3), the bigger the government contribution to the retirement plan.
- indemnity assistance, a percentage paid, depending on MMM location;
- subsidised continued professional development (CPD) which is mandatory to retain medical registration along with the cost to travel and staff cover
- housing, electricity, transport subsidies.
- subsidised childcare from community sources
- paid parental leave for both parents: financial and other support/incentives to partners/immediate family who also are with the rural GP

b. Current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
i. the stronger Rural Health Strategy

From the rural doctor's point of view, all the good ideas, and the hundreds of hours of work pointed to in the Strategy died with the outbreak of COVID - all attention was directed to the pandemic. It is important that all 50 Possible Solutions that this robust document addresses (National Workforce Strategy Preread) be revisited.

Potential solution 6: Develop an end-to-end incentivisation plan to increase trainee numbers in undersubscribed specialties

Potential solution 11: Consider salaried and single-employer models for rural GPs-in-training, with incentives to maintain service levels, access and quality

Potential solution 13: Develop pooled or block-funding models for Modified Monash (MM) 4–7 - (rural and remotMe) areas that offer greater flexibility.

Potential solution 19: Expand pathways that allow all or the majority of training to be completed in rural areas.

Potential solution 21: Continue to support national rollout of the rural generalist program.

Consider The Trailblazer Model from Sheffield in UK * to support newly qualified GPs to explore working in rural or deprived areas.

b. Current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,

In general, any attempt to differentiate rural versus urban is commended. We have now worked with the MMM model for many years and have found there is a firm and fair foundation. But distinct inequities that were not predicted, not predictable, no-one's fault, reveal clear obvious inequities. If the current government could fine-tune the DPA and MMM system, they would be recognised for an individualised bespoke attention to these rare but unfair allocations. Some examples include Tasmania, areas near urban areas which distance and modeling calculate a low MMM number, but who are suffering with lack of general practice. A non-government ombudsperson unaffiliated with the complainants could be assigned to reassign these areas to MMM3 or more. Overall, the MMM model has been a great improvement.

b. Current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
iii. GP training reforms

Particular attention to **Potential Solution 4:** Align college decision-making about accreditation and training numbers with the data, modelling outputs and decisions of the joint planning process. Also, we particularly recommend the following potential solutions:

Potential Solution 5: Inform and empower medical students and junior doctors with a nationally consistent, transparent and data-based tool to help them make career decisions.

Potential Solution 6: Develop an end-to-end incentivisation plan to increase trainee numbers in undersubscribed specialties.
Potential Solution 11. Consider salaried and single-employer models for rural general practitioners, with incentives to maintain service levels, access and quality.
Potential Solution 12: Develop mechanisms to support the portability of employment benefits, enabling doctors to work across different employers, regions and/or health services throughout their careers.
Potential Solution18: Collaborate with specialist medical colleges to identify and resolve the barriers to accrediting more high-quality rural training positions.
Potential Solution19: Expand pathways that allow all or the majority of training to be completed in rural areas.
Potential Solution20: Provide specific and adequate funding to compensate, develop and support supervisors in rural areas, including GP educators and supervisors.
Potential Solution 22: Ensure rural experience is included as a desirable selection criterion for positions, both in medical school and throughout doctors 'careers.
Potential Solution 26: Provide leadership development training and mentorship to aspiring rural trainees and future rural medical workforce champions.
Potential Solution 35: Increase high quality exposure to generalism in medical school and the prevocational years, potentially through a competency-based transition to practice approach.
Potential Solution36: Ensure selection criteria for entry into specialty training programs reward generalist experience and do not encourage early subspecialisation.
Potential Solution 37: Work with colleges to equip fellows with the right balance of generalist and subspecialist skills throughout their training and careers.
Potential Solution 38: Work with medical schools to determine if there is an evidence base for using medical school selection as a potential lever to increase generalism.
Potential Solution 46: Create transparency for doctors throughout the training pathway.
Potential Solution 47: Increase support for doctors to navigate and plan for their career pathway, particularly for undersupplied specialties and rural areas, and for Aboriginal and Torres Strait Islander doctors.
Potential Solution 48: Work with colleges to increase accreditation of non-metropolitan posts through governance processes and innovative supervision approaches.
Potential Solution 49: Right size 'the training pathway.
Potential Solution 50. Facilitate flexible approaches to training.

We also recommend the return of the Prevocational General Practice Placement Programme – which gave, and should give, medical students extended rotations in rural general practices.

Flexible funding is needed rural supervisors of trainees and MDRAP (More Doctors for Rural Australia Program) candidates to recognise their work and loss of income with any direct supervision with these non-college associated supervisory needs. This is itemised as **Potential solution 20**

b. Current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:

iv. Medicare rebate freeze;

Medicare rebate freezing must be avoided. It is felt severely in rural regions where private fees are not possible for socio-economic, demographic reasons, see the Rural Doctors Association comments on the Medicare Freeze (2015) here: **Cold-hard facts show why**

heat must stay on Medicare freeze

The freeze led to more patients presenting at local rural hospitals for GP-type care, putting more pressure on hospital emergency departments, increasing cost pressures on the hospital system, and resulting in more after-hours call-outs to the hospital for local rural GPs who would otherwise have seen these patients in their own practices during business hours.

Most rural general practices depend on near 100% bulk billing for their cashflow and livelihood. A Medicare freeze results in reduced income despite a steady increased cost of living as compared to our urban colleagues, who have the option of charging a gap to make up this difference. Medicare freezing is in short, a disincentive for rural general practice.

c. The impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia;

Rural Australia suffers more in a lockdown than urban Australia. It is not just doctor workforce shortages, but essential services and supplies shortages. COVID-19 has resulted in the loss of IMG workforce due to closure of the international borders; this is a rural specific issue. Medical centres have had to close despite the ongoing need for medical care of the rural residents.

d. Any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

- Childcare support services for GPs who are in training and who choose to live and work in rural Australia need to be fully subsidised.
- Infrastructure to rural Australia needs to be increased and improved – families need good schools and general practitioners who wish to work and live in rural Australia often face the dilemma of needing to move to metropolitan regions for the education of their children.
- Provision of rural and remote training for older doctors from metropolitan/urban regions, who are ready to take on new challenges and want a country change.

Yours sincerely,

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We acknowledge the Traditional Custodians of this land and their culture.
We also pay our respects to the Elders: past, present and future generations.

References:

Find the MJA article here:

https://www.mja.com.au/journal/2015/202/6/cost-freezing-general-practice

Find the NHPA report here:

http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Frequent_GP_attend ers_Report_March_2015.pdf

Find the AIHW report here:

http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550480

*__Trailblazer Model UK__ British Journal of General Practice 2020; 70 (692): 132-133. **DOI:** https://doi.org/10.3399/bjgp20X708641